MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01761

CERTIFICATE OF DEATH

Reg. Dist. No. 463

1. PLACE OF DEATH:

County Garrett

City or town Bloomington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Bloomington

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Charles Howard Beard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	widowed

6.(b) Name of husband or wife Pleasant Cora (Sullivan) Beard 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb-14, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	26	....hrs. ....min.

9. Birthplace Frankville, Maryland (Town, county, and state) Garrett Co.

10. Usual occupation Coal miner

11. Industry or business —

FATHER 12. Name James Beard

13. Birthplace North Mountain, W. Va.

MOTHER 14. Maiden name Sarah Wolfe

15. Birthplace North Mountain, W. Va.

16. Informant Vivian Beard

Address Bloomington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 12, 1945 (month) (day) (year)

Cemetery ~~or crematory~~ Bloomington

Location Bloomington, Md.

18. Funeral director Ellsworth Boal

Address Western Port, Md.

19. Feb 12 1945 (Date rec'd by registrar) Dorsey Pattison Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945 at 7a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1934 to Feb. 1945

and that I last saw h.../alive on February 9 1945

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E Berry MD M. D. or other

Address Piedmont, W. Va. Date signed 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 8 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

CERTIFICATE OF DEATH

01762

Reg. Dist. No. 166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Near Deer Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Garrett
City or town: Near Deer Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Infant DeWitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1945

8. AGE: Years | Months | Days | If less than one day: 3 hrs. ... min.

9. Birthplace: Near Deer Park Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Elwood DeWitt
13. Birthplace: Deer Park, Md.

MOTHER
14. Maiden name: Pleue Enlow.
15. Birthplace: Hages, Md.

16. Informant: Elwood DeWitt
Address: Deer Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 21, 1945 (month) (day) (year)
Cemetery or crematory: Deer Park.
Location: Deer Park, Md.

18. Funeral director: Emroy D. Bolden
Address: Oakland, Md.

19. 2/21 19 45 Juris Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2-20-45 L aA

20. DATE OF DEATH ... 19 ... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-19-45 to 2-20-45 19 ... 19 ...
and that I last saw him alive on 2-20-45 19 ...

Immediate cause	Instrumental Delivery pressure on head	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Oakland, Maryland Date signed 2-22-45

RECEIVED
MAR 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-2)

CERTIFICATE OF DEATH

01763/162
Reg. Diat. No.

1. PLACE OF DEATH:
County: Garett
City or town: Grantsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One Day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Jennings Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Simon Durst

3.(b) Social Security Number: 216-10-5385

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Florence Durst
6.(c) If alive, give age: 49 years
7. Birth date of deceased (mo., day, yr.): November 8-1890

8. AGE: Years	Months	Days	If less than one day
54	I	24	hrs. min.

9. Birthplace: Rural Near Jennings Md
(Town, county, and state)
10. Usual occupation: Saw Miller
11. Industry or business
FATHER 12. Name: Henry Durst
13. Birthplace: Rural Near Jennings Md
MOTHER 14. Maiden name: Barbra Hare
15. Birthplace: R.D.2. Grantsville Md
16. Informant: Mrs Florence Durst
Address: Jennings Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-1945 (month) (day) (year)
Cemetery or crematory: Grantsville
Location: Grantsville Md
18. Funeral director: Wm A Winebrenner
Address: Grantsville Md
19. Feb 3 1945 (Date rec'd by registrar) Esther Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1945 at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Feb 2 1945
and that I last saw h alive on Feb 2 1945
Immediate cause of death: Coronary Thrombosis — DURATION: 1 Hr.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. A. Davis M.D. (M. D. or other)
Address: Grantsville Date signed: Oct 3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 3 1965
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01764

Reg. Dist. No. 162

1. PLACE OF DEATH:

County: Garett

City or town: Rural Near Grantsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Garett

City or town: Rural Near Grantsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ervin Roy Hare

3. (b) Social Security Number: 215-05-7185

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Bertha Hare

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): November 1- X[illegible] 1891

8. AGE: Years	Months	Days	If less than one day
53	3	-	....hrs. ....min.

9. Birthplace: Rural Near Jennings Md (Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business

FATHER

12. Name: Wesley Hare

13. Birthplace: R.D.2 Grantsville Md

MOTHER

14. Maiden name: Anna Stark

15. Birthplace: Rural Near Jennings Md

16. Informant: MaRshell Hare

Address: Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-3-1945 (month) (day) (year)

Cemetery or crematory: Grantsville

Location: Grantsville Md

18. Funeral director: Wm Winteriug

Address: Grantsville Md

19. Feb 3 - 1945 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945; at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Feb 1 1945 and that I last saw h[illegible] alive on Jan 31 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: N. R. Davis M.D. M. D. or other

Address: Grantsville Md Date signed: Feb 2 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAR 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01765

Reg. Dist. No. 172

1. PLACE OF DEATH:
County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20yrs
Hospital, Institution, Street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. E. Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Antonio Petros James

3.(b) Social Security Number 213-01-6595

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Tina Beulah (Knotts) James
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): January 13, 1893

8. AGE: Years	Months	Days	If less than one day
52	1	3	hrs. min.

9. Birthplace: Mitelene, Greece (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mines

FATHER
12. Name: Lewis James
13. Birthplace: Greece

MOTHER
14. Maiden name: Kathleen
15. Birthplace: Greece

18. Informant: Mrs. Tina B. James
Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1945 (month) (day) (year)
Cemetery or crematory: I. O.O.F. Cemetery
Location: Elk Garden, W.Va.

18. Funeral director: Otho F. Sherpless
Address: Blaine, W.Va.

19. 2/17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 19 45 at 3:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead on Arrival 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ralph Caloundrella M.D
M. D. or other
Address Kitzmiller, md Date signed 2/17/45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

RE
MAY 4 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0F766

Reg. Dist. No. 172

1. PLACE OF DEATH:

County: Garrett

City or town: Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 8 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Kitzmiller

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nancy Louise Lucas

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1944

8. AGE: Years	Months	Days	If less than one day
0	3	18	..... hrs. ..... min.

9. Birthplace: Kitzmiller, Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER — 12. Name: William Isaac Lucas

13. Birthplace: Potomac Manor, W.Va.

MOTHER — 14. Maiden name: Kathleen Elizabeth Shillingburg

15. Birthplace: Elk Garden, W.Va.

16. Informant: Mrs. William H. Lucas

Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4, 1945 (month) (day) (year)

Cemetery or crematory: Odd F.

Location: Elk Garden, W.Va.

19. Funeral director: Otha F. Sharpless

Address: Blaine, W.Va.

19. 2/3 19 45 (Date rec'd by registrar) A.W. Barrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 19 45, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 19 45 to ..... 19 .....

and that I last saw h[illegible] alive on Feb. 2 19 45

Immediate cause of death	DURATION
Acute Bronchio-Pneumonia	7 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ralph Calandella M.D. M. D. or other

Address: Kitzmiller, Md. Date signed: Feb. 3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 7 1945
BUREAU C.T.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01767

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett

City or town Grantsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 1 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State Md County Garrett

City or town Grantsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jacob Wm Meyers

3. (b) Social Security Number 201-01-9049

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	widowed

6.(b) Name of husband or wife Malinda Kirkbride

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 27 1871

8. AGE: Years	Months	Days	If less than one day
74	2		..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Sawmill Hand

11. Industry or business Lumber

FATHER 12. Name Samuel Meyers

FATHER 13. Birthplace Cambria Pa

MOTHER 14. Maiden name Margaret Durst

MOTHER 15. Birthplace Md

16. Informant Harry Oerter

Address Grantsville Md

17. Burial Date thereof May 2 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meyersdale

Location near Kingwood Pa

18. Funeral director Wm Whitehair

Address Grantsville Md

19. Feb 27 1945 Esther Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1945 at 7.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Feb 27 1945 and that I last saw him alive on Feb 25 1945

Immediate cause of death	DURATION
(a) Bronco Pneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. R. Davis M.D.
M. D. or other

Address Grantsville Md Date signed Feb 27 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAR 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

01768

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: Rural Near Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Rural Near Grantsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Elias S. Miller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Febuary 16-1852

8. AGE: Years	Months	Days	If less than one day
93	-	5	..... hrs. ..... min.

9. Birthplace: Rural Near Oakland Md (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business

FATHER
12. Name: Samuel Beachy
13. Birthplace: Elk Lick T.S. Somerset Co Pa

MOTHER
14. Maiden name: Elizabeth Yoder
15. Birthplace: Berlin Pa

16. Informant: Irvin Miller
Address: R.D.I. Salisbury Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-24-1945 (month) (day) (year)
Cemetery or crematory: Mapel Glen
Location: Rural Near Grantsville Md

18. Funeral director: Wm. Winterberg
Address: Grantsville Md

19. Feb 23 1945 (Date rec'd by registrar) Esther Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1945 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 22 1945
and that I last saw h[illegible] alive on Feb 19 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	2 hrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. R. Davis M.D.
M. D. or other
Address: Grantsville Date signed: Feb 23 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 3 1965
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

01769

Reg. Dist. No. 166

1. PLACE OF DEATH:

County: Garrett

City or town: Oakland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 years

Hospital, institution, or street address where death occurred: Mason St.

How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Oakland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mason St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3. (a) FULL NAME: Susan Almeda (Gower) Miller

3. (b) Social Security Number: — ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Truman Miller

6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): December 12, 1863

8. AGE: Years	Months	Days	If less than one day
81	1	23	....hrs. ....min.

9. Birthplace: Oakland; Garrett Co., Md. (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own Home

FATHER — 12. Name: Jacob Gower

FATHER — 13. Birthplace: Garrett Co., Md.

MOTHER — 14. Maiden name: Susan N. Wilt

MOTHER — 15. Birthplace: Garrett Co., Md.

16. Informant: Daniel Miller

Address: Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1945 (month) (day) (year)

Cemetery or crematory: Oakland Cemetery

Location: Oakland, Maryland.

18. Funeral director: Herbert C. Leighton

Address: Oakland, Maryland.

19. 2/7/45 (Date rec'd by registrar) Jules Ronan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1945 at 8:15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 1944 to Feb 4 1945

and that I last saw h~~e~~ alive on Feb 3rd 1945

Immediate cause of death: Coronary emb — DURATION

Due to: Chronic Nephritis 3 yrs

Due to:

Other conditions: Chronic Bright's 4 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. C. Hunsbarger M. D. or other

Address: Oakland Md Date signed: 2/7/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAR 12 1945
BUREAU

STATE OF MARYLAND—CERTIFICATE OF DEATH

1770

1. PLACE OF DEATH

County Garrett — Registration Dist. No. 167

Village or City Kempton — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Buford Bailey REED

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	widower

5e. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mecca Smith Reed (deceased)

6. DATE OF BIRTH (month, day, and year): Sept. 24, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Coal miner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and year): 1942

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town): Raleigh County

(State or country): W. Virginia

FATHER

13. NAME: Buford Reed

14. BIRTHPLACE (city or town)

(State or country): Virginia

MOTHER

15. MAIDEN NAME: Sarah Fergusson Mills

16. BIRTHPLACE (city or town)

(State or country): Virginia

17. INFORMANT: Mrs. Edgel Wilson

(Address): Kempton, West Va.

18. BURIAL, ~~CREMATION~~, OR REMOVAL

Place: Thomas, WestVa. Date: Feb. 11, 1945

19. UNDERTAKER: J.D.D. Duncan

(Address): Thomas, West Va.

20. FILED: 2/11, 1945 — Elmer C. Shaffer, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February 8, 1945

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from 2/1, 1945, to 2/8, 1945

I last saw h~~im~~ alive on 2/8, 1945; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of head of pancreas	2
Obstructive jaundice	2 mo.

Other Contributory Causes of importance:

Senility	
Gen. arteriosclerosis	

Name of operation: Date of:

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury: , 19

Where did injury occur? —

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) H. L. Carter M. D.

(Address) Thomas W. Va.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

REC'D MAR 5 1925 BUREAU

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN